Statement of

Ashok Rai, M.D.

President and Chief Executive Officer, Prevea Health

On

MACRA and MIPS: An Update on the Merit-based Incentive Payment System

Before the Subcommittee on Health

Of the

Committee on Energy and Commerce of the U.S. House of Representatives

July 26, 2018

Chairman Burgess, Ranking Member Green, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of AMGA. Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems that employ more than 175,000 physicians who care for one-in-three Americans. I serve as chair of AMGA's board of directors and throughout my experience with this organization, I have witnessed these medical groups work diligently to provide innovative, high-quality, patient-centered medical care in the most efficient manner possible.

Since 2009, I have served as President and Chief Executive Officer of Prevea Health, a multispecialty group in Green Bay, Wisconsin, that offers over 60 medical specialties, and employs about 350 providers and more than 2,000 employees. I am a board-certified internist and have practiced medicine for over 17 years. In that time, I have witnessed and helped lead major transformations in care delivery throughout Prevea Health.

First of all, I wanted to thank Congress for eliminating the Sustainable Growth Rate (SGR) formula in its attempt to bring more stability to the Medicare Part B program. As you know, the SGR formula necessitated continuous fixes every year, forcing policymakers to think in the short term, and we appreciate that we now have the opportunity and ability to plan for the future. Congress' subsequent passage of the landmark Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 by adjusting payments based on quality and other key factors, represents an opportunity for providers to begin to move away from the current fee-for-service reimbursement model and transition towards value-based care.

MACRA is designed to reward providers by adjusting their Part B payments, which are based largely on the quality of care they provide. In guidance and public comments before it promulgated rules on MACRA, the Centers for Medicare & Medicaid Services (CMS) purported that the law would help achieve three goals for the healthcare system—better care, smarter spending, and healthier people. The law and regulations would achieve this by rewarding physicians who performed well in three key areas: payment incentives, care delivery, and information sharing. Per the MACRA statute, CMS implemented the program by streamlining existing initiatives under the new Merit-based Incentive Payment System

(MIPS) program. Specifically, the program includes the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Meaningful Use (MU) program. And, for those providers further on the pathway to value-based care, it provides bonus payments for participation in eligible Alternative Payment Models (APMs).

Like many AMGA members, Prevea Health has made significant investments in people and technology in response to MACRA. Prevea Health has been using an electronic health record system for 16 years, so we have thorough access to data on our patient population. But, having data and utilizing it are two different things. We have made investments in platforms that identify gaps in our patients' care and enable us to address them. We also streamlined how our patients interface with us. For example, we offer online appointment scheduling, which has simplified the process for our patients and providers. We continue to make multiple investments in data analytics to improve our patient population's health. Additionally, we are investing in diversifying our provider population. For example, we successfully improved patient and provider satisfaction by hiring multiple registered nurse (RN) care managers. We found that those patients who were managed with a care manager cost a third of what those managed solely by a physician cost. We also have quantifiable evidence that patients with chronic disease who are managed in our patient-centered medical home model have better outcomes and cost the healthcare system less.

These investments were made based on the understanding that MACRA would be implemented with the intent to reward value and innovation. Now, in the third year of rulemaking, it is clear that CMS is not implementing MIPS as intended by this Committee and Congress. If changes are not made, MIPS will not drive change at the clinician level or transition Medicare Part B to value-based reimbursement.

Under the MIPS program, providers have the opportunity to earn an annual adjustment to their Medicare Part B payments based on their performance. These adjustments increase over time. For example, based on performance in 2017, payments would potentially adjust up to 4% in 2019. Performance in 2018 will adjust payments in 2020 up to 5% for top performers. For performance in 2019, top performers could potentially be rewarded a 7% payment adjustment in 2021. Also, in 2019 performance year, a 9% payment adjustment could be rewarded to top performers for 2023. Conversely, as included in the law, poor performance will result in negative payment adjustments of -4%,-5%,-7%, -9% in 2019, 2020, 2021, and 2023 respectively. However, these payment adjustments assume meaningful participation in the program, since Congress designed MIPS to be a budget-neutral program.

We believe that CMS has bypassed the intent of MACRA by excluding 58% of providers from MIPS requirements for performance year 2019 in the recently proposed Quality Payment Program (QPP) or MACRA rule (CMS-1693-P). This exclusion will result in negligible payment adjustments for high-performers that have made meaningful investments to improve quality of care for the communities they serve. This action effectively collapses the MIPS payment adjustment distribution curve. As a result, the payment adjustment for 2021 of up to 7% instead is projected to be 2% for high performers. In fact, CMS has included some form of exclusions to MIPS in all past QPP rules. In 2019, MIPS high performers are expected to receive 1.1%, based on their 2017 performance, even though the law authorized an adjustment up to 4%. In 2020, high performers are expected to receive a 1. 5% adjustment, but they were working under the understating that they could potentially earn up to a 5% payment increase.

As you know, MIPS is a not a brand-new program, rather a continuation of existing value-based programs, namely PQRS, VM, and MU. CMS did not exclude providers from these programs, as it has from MIPS. Prevea Health utilized its time reporting to these legacy programs to streamline the eventual transition to value. As a result, our efforts to perform in these legacy programs have improved the quality and value of our care. In the four tax identification numbers that Prevea Health bills under partnership with our hospital partners, Hospital Sisters Health System, we scored three perfect scores of 100 and one of 97. However, because of the MIPS exclusions, our payment adjustment does not reward us for this performance.

If Medicare providers are going to successfully transition to value-based arrangements, more of them should be subject to MIPS. I realize that some providers may lack the resources to participate in these programs, but as mentioned above, this transition has been a work in progress for years. In addition, CMS provides technical support and favorable scoring for some providers. Our patient population deserves a provider workforce that is willing and capable of providing the best level of care possible. These MIPS exclusions do not prepare practices of any size to transition to a post fee-for-service payment environment and unfairly penalize those who have worked in good faith to make that transition.

CMS has implemented policies that exclude otherwise eligible clinicians and set a low composite performance score threshold, which determines the physician payment adjustments under MIPS. The resulting payment adjustments for high performers in the program will neither incentivize the required investments in health information technology and process changes, nor will they cover the costs and burdens associated with reporting the required data. Finally, they will not incentivize healthcare provider organizations to engage with CMS in moving toward value-based care.

We commend this Committee on its commitment to MACRA implementation oversight and stand ready to assist you in this process. Thank you for the opportunity to testify.